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New Client Information Form

Name_____

Date of first appointment _____ **Birthdate:** ____/_____/_____

Mailing Address_____

Phones (H)_____**(C)**_____**(W)**_____

Email address: _____

Referral Source_____

Employer Name & Company Address: _____

_____

Position_____ **Length of Current Employment:** _____

Are you happy with your current employment? _____

Living Situation: Married Living Together Single Divorced Widowed Separated Room-Mates Single Parent

Marriage(s) / Date: _____

Divorce(s) / Date: _____

Children / Step-Children? List names, ages:_____

_____

Emergency Contact_____ **Relationship**_____

Phone: (H) _____ **(W)** _____ **(C)**_____

Address_____

Your goals for Counseling: _____

_____

Social Support:
____I have only acquaintances **____I have one close friend**

____I have acquaintances and more than one close friend

How many CLOSE friends do you have? _____

Do you find it difficult to discuss your feelings? Yes No Sometimes Easy to discuss

List your hobbies, interests and activities_____

_____

Education: Years of school completed_____ **Type of College Degree/s** _____

Religion_____ **Active? Yes No**

Physical Health Status: Excellent_____ **Good**_____ **Fair**_____ **Poor**_____

Physician Name_____ **Phone**_____

Address_____

Date of Last Check-Up_____ **Reason?**_____

Weight Changes in Last Year? Yes No If so, what changes?_____

_____ **Appetite Problems? Yes No Sometimes**

Sleep Problems? Yes No Sometimes Explain_____

List any physical or emotional symptoms/problems and any relationship problems you are experiencing NOW

or have experienced in the last year_____

_____

_____

I hope the counseling will result in…_____

_____

_____

Sexual Orientation Heterosexual_____ **Lesbian/Gay**_____ **Bisexual**_____ **Unsure**_____

Previous Counseling?_____

_____

Have you ever attempted suicide? Yes_____ **No**_____ **How many times**_____ **When**_____

Do you currently feel suicidal? Yes_____ **No**_____ **Sometimes**_____ **If so, please explain**_____

_____

Usual number of alcohol drinks? Each Day_____ **Each Week**_____ **Type of Alcohol**_____

Alcohol-Related Tickets? Yes___ **No**___ **Complaints about your drinking/drugging? Yes**____ **No**____

List all Mood-Altering Drugs Used in Past 10 Years_____

Parents Names and Ages_____

Brothers and Sisters Names and Ages (include yourself)_____

_____

Did you experience sexual abuse as a child? Yes____ No____ Uncertain____ By whom?_____

Did you experience physical abuse as a child? Yes____ No____ Uncertain____ By whom?_____

Did you experience emotional or psychological abuse as a child or adult? Yes____ No____ Both ____ Uncertain____

Please describe

_____

_____

Have you experienced violence as an adult? _____

Do you use any alternative practitioners for healing? Yes ___ No ___

What types of healing do you receive? _____

Practitioner(s) name & location: _____

_____

Have you ever been Hypnotized? Yes No Was it helpful? Yes No

Hypnotized for _____

Do you see a Psychiatrist? Yes No Name & Phone _____

List any medications you are currently taking: _____

_____

I agree to participate in Out-Patient Psychotherapy sessions with Alyse Rynor, LCSW.

Signature_____ **Date**_____

Insurance Information

Insurance Company _____ Policy ID# _____

Group # _____Insured_____ Deductible_____ Co-Pay____

Date of Birth of Insured____/_____/_____ Address to send claims: _____

_____

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Fee and Payment Agreement

I, _____, hereby agree to pay Alyse Rynor, LCSW aka Soul Choice Counseling, Ltd. the fee of $ 130.00 per session for counseling/psychotherapy services. I understand that payment (or insurance co-payment) is due at the beginning of each appointment. **I also understand that I am required to give 24 hours notice in order to cancel or change my appointment. I hereby agree to pay $95.00 for any appointment that I fail to cancel 24 hours ahead of the time my appointment was scheduled to begin.**

I hereby give permission to bill my insurance company for clinical counseling services and to provide documentation required by my insurer to authorize provision of services or to submit insurance claims by M & D Billing services, Plainfield, IL.

Client Signature/s_____ Date_____

Witness Signature_____ Date_____

Mailing Address_____

City, State, Zip Code_____

Phone #s _____ _____ _____

Email (please print clearly)_____